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DIFFICULT CASES: WHAT SHOULD “ A ” DO ?*

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Problems always persist, in spite of the routine nature of the work.

At King's College Hospital I deal only with female gonorrhœa, as the syphilis cases are all treated in the skin department. I attend my clinic three sessions of two hours weekly, and have a Nurse in daily attendance for treatment. I have one bed.

Women and children with all types of discharges come to me for diagnosis. Some come from the Gynæcological and Ante-Natal Department of the Hospital, others from the Local Borough Clinics and from General Practitioners. A few come up independently. A great many are non-venereal in origin, *e.g.*, leucorrhœa of pregnancy, chronic non-specific endocervicitis of married women, and the numerous cases of cervicitis and vaginitis of unmarried girls which are without doubt largely venereal in origin in the true meaning of the word, because originating in sexual intercourse under unhygienic conditions but non-venereal within the meaning of the Act. The problem in dealing with these cases, and especially with the latter class, is this: Am I justified in treating any of them in my clinic, and if I do not treat them, who will?

The patient suffering from endocervicitis can go back to the Gynæcological Department, although she is not welcomed there and is very often inadequately treated.

The patient with leucorrhœa of pregnancy badly needs attention in view of the importance of treatment directed towards the elimination of sepsis in labour and of ophthalmia neonatorum of the child. The Ante-Natal Clinics with which I deal give no routine treatment in these cases. The unmarried girl suffering from non-specific trouble can only come to us and form a class of the most intractable type to treat.

* Based on an address delivered before the Medical Society for the Study of Venereal Diseases, November 25, 1932.

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This, then, is the first problem to put before you. In your opinion, how far am I justified in keeping any of them on as patients in this clinic ?

Coming now to the more or less definite specific cases of gonorrhœa in women and children, I shall classify my difficulties under the following headings :—

- (1) Sociological, domestic and economic.
- (2) Diagnostic.
- (3) Difficulties of treatment.

I. SOCIOLOGICAL, DOMESTIC AND ECONOMIC

These arise in dealing with women as out-patients : My clinic serves a wide area and women come to me from districts as far out as Croydon, Bromley, Catford, West-ham, Biggin Hill, etc. They are respectable married women, working class, and unmarried girls standing all day in tea shops and behind counters. None of them are able to rest at home or give up work. They find it difficult to come up as often as necessary in the early stages and have not the facilities at home to give themselves adequate hygienic treatment there.

Feeling that complete rest in the early stages of an acute infection is all important, and that regular douching of the passages, or even rest alone, will do more than I can do to cure them by having them up for treatment ; how far am I justified in not insisting on the former and in trying to carry on with a routine treatment with which either they often subside into the difficult-to-cure chronic state or run the risk of developing an ascending infection in addition to being a potential source of danger to the community ?

Patients suffering from acute gonorrhœa would generally cease to exhibit clinical symptoms if they went to bed and douched daily. They would be saved from the secondary infections which convert an acute discharge into a chronic one.

This, then, is my second problem.

DIFFICULTIES OF DIAGNOSIS

These are always present, in spite of efficient film reporting, culture growths and sensitive C.F.T. for gonorrhœa.

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Are we justified in labelling cases as V.D. when we have never, even after repeated tests, found confirmatory bacteriological evidence of clinical signs and symptoms pointing to the presence of the g.c.?

Then there are the children who come to us, very often after in-patient treatment in hospital for scarlet fever, measles, etc., suffering from vaginal discharge.

We do not find the g.c. in the vaginal smear, nor in the culture, merely pus cells, epithelial cells, gram — bacilli and gram + organisms. For how long are we to keep the child away from school? Prolonged clinical treatment, at a most impressionable age, leads inevitably to the habit of masturbation. To put her under suspicion of V.D. adds one more worry to her hard-working mother's life.

PROBLEMS OF TREATMENT

(1) The carrier question, cases which are asymptomatic but from time to time show g.c. +ve in smears.

(2) Prophylactic treatment in cases of those who have run risks of infection. Should they be treated or should one wait for symptoms to develop?

These then are my personal problems. I realise that they may be minor ones, and that far more serious questions arise for those who are working in a larger field. But I was asked to talk about personal difficulties and not theoretical ones, and so I have done so.

DISCUSSION

Major DOBLE considered the paper a splendid one, as it was the practical problems and their solution which were so helpful. She commenced by asking where certain cases ought to be treated, such as those who were discharged after measles, etc. He once gave evidence in a case in which he said that a certain lady had not any type of venereal disease, and the judge asked him when he arrived at that conclusion. On hearing the date he said, "Did you continue to treat her?" Major Doble answered, "Yes," and the judge retorted, "You amaze me." His (the judge's) idea being that non-venereal cases should not be treated in a V.D. clinic.

Dr. SHARP said he had no opinion to offer as to where young people with non-gonococcal infections should be

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dealt with, but asked whether there was a really effective treatment of them. He had found that in non-gonorrhœal cases of vaginitis in young girls local treatment of the vagina was of no avail. The only effective treatment was that of the associated causal condition, the most common of these being threadworms. Indeed, if no other condition was found answerable, one was generally safe in diagnosing threadworms. Uncleanliness and intertrigo would keep up a vaginitis. Or there might, as a rarity, be a foreign body in the vagina. He did not know whether the same applied to girls over puberty who had contracted vaginitis in a venereal manner, yet had not caught the specific infection. If there was no treatment for this condition and it did not do harm, why not leave things as they were?

With regard to the treatment of cases suspected of possible infection, he agreed with the course which had been mentioned in the paper. One should not start treating a supposed disease until one was certain the disease was present. Bacteriological tests should be repeated for a sufficient length of time, and treatment withheld till a positive result was obtained, if at all.

Dr. MARGARET RORKE said she appreciated Mrs. Hemmant's paper very much. Her own great comfort was to hear that there were intractable cases in men, *i.e.*, cases of gonorrhœa. Some might think the chronic cases were among women only, also cases of non-specific discharge. Some of the questions which Mrs. Hemmant asked could only arise now in a time of a more active social and public conscience on health subjects; such questions would not have arisen twenty years ago. That, however, might appear to be begging the issue. All who worked at women's clinics had the same trouble: patients coming a great distance, patients too poor to pay the fares to the clinic to have adequate treatment; and they were too poor to get adequate food vitamins or well-balanced food. Nearly all these patients were under par. She did not think a better out-patient clinic would cure many of these conditions of our time. The cases of the young girls mentioned were very difficult ones; they were venereal in the real sense of the word, but not cases of venereal disease recognised by the Ministry of Health for treatment. When asked where they should be treated the answer of the Authorities was "Not in the V.D. Clinic." Theore-

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tically, the Panel doctor should be able to deal with them. She thought that much of the discharge in young girls was due to illicit intercourse, indulged in fairly frequently, and under bad conditions, and always associated with *B. coli* infection. Often this infection was the start and finish of the whole condition, and a badly-loaded bowel kept up a septic cervicitis, and no treatment would relieve that as long as the predisposing conditions were indulged in. Children with non-specific discharges were better not in the V.D. Clinic. If they had vaginal discharge after bad scarlet fever, etc., then fresh air, better conditions, a tonic, and seeing that no bowel infection with worms was present, were indicated.

Mr. LEES wished to add his tribute to both Major Doble and Mrs. Hemmant for initiating a most interesting discussion. The sociological problems mentioned by the latter would always be with us until Hospital Authorities recognised that more beds were required for the type of case she described, and especially for cases of female gonorrhœa. Local Authorities must realise that the provision of beds for acutely contagious cases would help in preventing the spread of infection. So far as his experience went, salpingitis was not likely to eventuate in cases of cervical gonorrhœa if the patient was hospitalised for the first three or four weeks of the infection. When a true salpingitis developed, in-patient treatment was essential. He realised to the full the difficulty of dealing with cases in which microscopic evidence did not prove a gonococcal infection, while the clinical condition strongly suggested it. Repeated bacteriological tests were necessary in these cases, and cultural tests were often of even greater value. In his experience, the insertion into the cervix of a plug of gauze soaked in glycerine for twenty-four hours prior to taking the test increased their value. In doubtful cases he had found the cuti-reaction performed with a gonococcal antigen of considerable value. In a series of 1,000 cases tested by one of his assistants, the result gave 80 per cent. positive tests and a comparatively small number of false positives—about 1.5 per cent. In dealing with children, there was, in his experience, very little difficulty in diagnosing acute cases of vulvo-vaginitis. The urethra was almost invariably infected, and films should always be taken from this area as well as from the vagina. Hospital beds were imperative

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in these cases as the patients were a risk to other children. He looked on them as cases of emergency and admitted them to hospital at once. They were extremely intractable so far as definite cure was concerned, although the clinical condition improved rapidly under hospital treatment.

With reference to the type of girl who complained of persistent vaginal discharge, it was important to make certain that such a patient was not perpetuating the discharge by constant douching with Lysol. Lysol was commonly used as a douche, and in his experience it very frequently caused an irritative vaginitis. Cessation from douching, or the use of a douch of bi-carbonate of soda, often proved effective in clearing up this discharge. He scarcely agreed with those who advocated waiting until disease developed in a married person before instituting treatment. If he had knowledge of a person who had developed disease, and who since developing that disease had risked his other partner, he always advocated prophylactic treatment of the husband or wife who had been exposed to infection. While admitting that prophylactic treatment could not be carried out as efficiently in the female as in the male, he still thought it was worth attempting. Douching of itself was of little use in such cases in the female, and it required topical application of antiseptic to the urethra, the cervix, and the bartholinian duct. In any patient to whom prophylactic treatment had been administered, subsequent observation was of paramount importance, and in the case of a female patient this observation should be continued at intervals for a period of three months, and certainly after three menstrual periods. It was certainly more in the interests of public health to try to prevent the onset of disease than to adopt a passive attitude and watch for the development of disease.